

## General Medicine Scenarios

### **Scenario 1 of 6:**

**Chief Complaint:** Sore throat

**HPI:** The patient is a 18-year-old man being evaluated for a 3-day history of sore throat, cough, fever, and chills.

**Past Medical History:** None.

**Review of Systems:** As above.

**Physical Exam:** Temp.= 102. Patient appears ill. Pharynx is red, tonsils are enlarged with extensive yellow exudate. Positive cervical adenopathy bilaterally. Lungs are clear.

RSA is positive.

**Assessment and Plan:** Strep pharyngitis - start antibiotics.

**Scenario 2 of 6:**  
**Emergency Department Services**

**HPI:** Patient is a 24-year-old female with a history of asthma who presents to the ER complaining of 3 days of worsening respiratory symptoms. She has increasing SOB, no chest pain, no productive cough, and no fever. She has awakened the last two mornings with wheezing only partially relieved with inhalers.

**Past Medical History:** Asthma, on inhaled steroids. Previously hospitalized and intubated.

**Review of Systems:** As above.

**Physical Exam:** Thin young female in moderate respiratory distress. Afebrile, RR= 26. Patient is unable to talk in complete sentences, she is using accessory muscles to breathe. Breath sounds are distant with minimal wheezing in all fields.

CXR is negative for infiltrates.

**ED Course:** Nebulizer treatments, IV steroids with improvement in respirations. Patient has decreased use of accessory muscles and is able to complete sentences. There is increased wheezing on exam.

**Clinical Impression:** Asthma exacerbation

**Disposition:** Admit to ICU for observation and continued nebulizer treatments, steroids.

**Scenario 3 of 6:**

**Chief Complaint:** Fever and cough

**HPI:** The patient is a 21-year-old woman being seen for the acute onset of fever, myalgia, arthralgia, and nonproductive cough.

**Past Medical History:** Noncontributory.

**Review of Systems:** As above.

**Physical Exam:** Temp.= 102, RR= 18. A few crackles are heard at the left lung base.

Leukocyte count is 14,000/uL ( $14 \times 10^9$  L). Chest x-ray shows an infiltrate at the left base.

**Assessment and Plan:** Community-acquired pneumonia - start antibiotics.

**Scenario 4 of 6:**

**Reason for Visit:** Establish medical care.

**HPI:** A 59-year-old male presents to the office as a new patient without new complaints. He states he is compliant with medications, diet and blood sugar monitoring. He denies chest pain, polyuria, polydipsia or edema. He is not sure when last labs were done prior to this appointment's pre-visit labs.

**Past Medical History:** Positive for HTN, Diabetes Type 2, on meds.

**Review of Systems:** As above.

**Physical Exam:** Moderately obese middle-aged male in no acute distress. BP= 122/82, P= 68, RR= 12. Cardiovascular, pulmonary and neurologic exams are WNL.

Lab: Total cholesterol= 250, LDL= 160, HDL= 30, TG= 210

**Assessment and Plan:** Hypercholesterolemia, start meds, recheck labs in 3 months.

**Scenario 5 of 6:**

**Reason for Visit:** Left heel pain.

**HPI:** 48-year-old male factory worker presents with complaints of left foot pain for 3 months since buying new work shoes and being transferred to a new line at his factory which requires more walking on the factory's cement floors. Pain is sharp or burning, worse when he first wakes up and attempts to stand and worse with prolonged weight bearing or walking.

**Past Medical History:** Unremarkable.

**Review of Systems:** As above.

**Physical Exam:** Moderately obese middle aged male in no acute distress. Left foot is tender to palpation along sole at the anterior edge of the heel and tender with dorsiflexion. There are no lesions or edema.

**Assessment and Plan:** Plantar fasciitis, NSAIDS, OTC shoe inserts, stretching exercise. Return in one month for re-evaluation

**Scenario 6 of 6:**

**Reason for Visit:** Depression

**HPI:** 32-year-old male presents with complaints of worsening depression. Symptoms started 6 months ago after he lost his job to company downsizing. He has been unable to find another position and was forced to move in with his parents due to finances. He states he feels like a failure. He is cut off from friends and reports feeling isolated. He admits to thoughts of suicide but denies having a plan or making an attempt. He is not sleeping and has lost approximately 15 pounds.

**Past Medical History:** Depression episode twelve years ago treated with medications and psychotherapy. No hospitalization.

**Review of Systems:** As above.

**Physical Exam:** Well developed male appearing tired and anxious. He is alert and oriented. Neurologic exam is normal except for Beck's depression scale.

**Assessment and Plan:** Major depression with suicidal ideation. Emergency psychiatric consult for admission and treatment.